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Asset-Based Community Capacity Building: A Process for Expanding a Retirement Home Physical Activity Program

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Abstract

The population is aging rapidly and physical inactivity and sedentary behaviour are on the rise, a trend noticed at a northern Ontario retirement home looking to improve the choices for, and attendance at, physical activities provided for residents. A community capacity building (CCB) approach using an asset-based, partnership methodology was utilized to create internal and external asset maps. These maps were used to inform potential partnerships within the community. Partnerships were recommended with a university, college, and two high schools, whose staff and students could help to implement new physical activities. Walking and gardening clubs were presented as examples that could be implemented using identified assets. An adapted model was then presented that the home could use in the future to explore other partnerships and continue to build capacity for its physical activity program.

Keywords

community capacity building, asset-based approach, asset-map, partnership development, physical activity, older adults

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Chapter 1

1 Introduction

In response to a quality assurance initiative concerning the level of physical activity of the residents at a retirement home, the purpose of the present study was to make recommendations on what could be done to improve the choices of physical activities provided for the residents. The goal was to provide the retirement home with a quality improvement process, rather than just a finite list of recommended physical activities to offer the residents. A community capacity building approach using an asset-based, partnership methodology was utilized. An adapted community capacity building model was proposed to provide the retirement home with a process to follow so that future physical activities offered could be modified and expanded when deemed necessary.

1.1 Background

The concern expressed by the retirement home seemed timely. While the home had a physical activity program in place, the participation records described by the home indicated that few residents took advantage of the existing program and indeed many residents were largely sedentary. In line with this, an overwhelming volume of current research speaks to the lack of physical activity by older adults and a sharp rise in sedentary behavior. The World Health Organization (WHO) has identified physical inactivity “as the fourth leading risk factor for global mortality” (World Health Organization, p.7, 2010). This issue is particularly pertinent in senior living facilities (i.e. long-term care and retirement homes), where a large portion of residents are inactive and tend to spend much of their days in a sitting or lying position (den Ouden et al., 2015; Kalinowski et al., 2012; Talbott & Roberson, 2011). Importantly, sedentary behavior (defined as prolonged sitting or lying) has been identified as a risk factor for poor health, distinct from physical inactivity (Owen, Healy, Matthews, & Dunstan, 2010).

An attractive physical activity program has the potential to increase physical activity and to decrease sedentary behavior, thereby improving health and quality of life for retirement home residents. For those 65 years and older, the World Health Organization

stated that physical activity can include activities such as walking, dancing, gardening, hiking, swimming, transportation such as walking or cycling, household chores, play, games, sports or planned exercise (World Health Organization, 2010, 2011). In keeping with the literature on the prevalence of physical inactivity and sedentary behavior, the WHO (World Health Organization, 2010) acknowledges that any physical activity is better than none, particularly for those over the age of 65 years who may be physically limited in what they can do. The strategy used by this retirement home (and many others) was to offer a slate of discretionary physical activities from which the residents could choose, a strategy that this study was to adhere to. This style of program is in line with research that has shown that offering residents activity choices helps in the transition from independent living in the community to retirement living, having direct positive effects on well-being and quality of life (Winstead, Yost, Cotten, Berkowsky, & Anderson, 2014).

A critical piece of information gained from initial conversations with the home was the fact that very few additional financial resources were available to support the suggested changes that could be made as a result of the present work. Practical experience suggested that this stipulation is not uncommon in the real world of health promotion. Agencies are often faced with limited financial resources to initiate, continue, or expand programs (Kretzmann & McKnight, 1993; Labonte, Woodard, Chad, & Laverack, 2002). A strategy that has often been employed under these circumstances is to use a community capacity building framework, where taking advantage of existing assets is often necessary (Beaulieu, 2002; Kretzmann & McKnight, 1993). Community capacity building (CCB) is meant to be an ongoing empowering strategy, operating at various levels from the individual, to the organization and beyond (Baillie, Bjarnholt, Gruber, & Hughes, 2008; WHO, 1997). As Baillie et al. (2008) suggest, capacity building is a continuous process, allowing it to meet changing circumstances and needs, something that seems a certainty for retirement homes.

While CCB seemed to be a very useful framework practically for the present work, it also had merit conceptually. Engagement with one’s community is an important aspect of quality of life for residents in retirement living, particularly during the transition from

independent living in the community, to retirement living within a “home” setting. Research shows that older adults in retirement homes are often at risk of being lonely and depressed because of the loss of contact with their previous social connections (Adams, Sanaders, & Auth, 2004). Opportunities to be involved with the community can provide older adults in retirement homes purpose and ultimately a higher quality of life (Cannuscio, Block, & Kawachi, 2003; Singleton, n.d.). Community engagement and connection is also a cornerstone of the Age Friendly movement in Canada (World Health Organization, 2007). Opportunities for intergenerational engagement can also positively impact retirement home residents’ quality of life (Kaplan, Liu, & Hannon, 2006).

Finally, while the forming of partnerships is a fundamental aspect of a CCB approach (Kretzmann & McKnight, 1993; Wescott, 2002; World Health Organization, 1997b), this strategy at the level of the individual resident could also enrich social ties. There is a large body of research that links social networks and social support to health and quality of life in older adults (e.g., Seeman, Lusignolo, Albert, & Berkman, 2001; Snowden et al., 2015). Importantly, for retirement home living, van Woerden, Poortinga, Bronstering, Garrib, and Hegazi (2011) found, as assessed by self-rated health, that social support from “other sources” like friends and civic participation, could compensate for support from family. In light of the points outlined above, further research concerning the use of a CCB framework to guide this work is reviewed below.

1.2 Community Capacity Building Review

Community can be defined in a variety of different ways, in reference to a place (physical location, workplace, etc.), a social system (networks and connections, interactions between people, etc.) or an interest-based group (mixed group of people sharing needs, tasks, interests, etc.). In the present study, the community included the city, the retirement home, and its residents. Commonly in the literature, definitions of community contain some combination of the following: a mixed group of individuals who share something and act collectively, typically based in geography, networks and organizations, aspirations, needs and interests or bonds and ties (Verity, 2007). Capacity often refers to “the ability to carry out stated objectives”, or a process and an

outcome (Brown, LaFond, & Macintyre, p.iii, 2001). Putting the two concepts together, Gibbon, Labonte, and Laverack define community capacity “as the ‘increase in community groups’ abilities to define, assess, analyse, and act on health (or any other) concerns of importance to their members” (Gibbon, Labonte, & Laverack, p.485, 2002).

Common within CCB literature, the frameworks described regularly reference dimensions that help provide a focus for assessing, planning, implementing, and evaluating various CCB strategies (Baillie et al., 2008; Labonte & Laverack, 2001a; Verity, 2007). Although the specific details of CCB conceptualizations of capacity and building strategies vary among projects, Baillie et al.’s (2008) framework provides a useful summary of the dimensions most commonly seen. In their framework, the key foundations for building capacity include resourcing, leadership, and intelligence. Resting on these foundational elements are key strategic domains, represented as partnerships, organisational development, project management quality, work-force development, and community development (Baillie et al., 2008). The process of CCB may include: asset mapping, training, shared planning, leadership development, mentoring and communication flows (Baillie et al., 2008; Verity, 2007). As suggested by Mathie and Cunningham (2003), however, there is no set blueprint for CCB, and the processes adopted for different projects often vary considerably. Several aspects of Baillie et al.’s (2008) framework, particularly the key building blocks and the partnership strategy, are embedded both explicitly and implicitly in the work reported below.

1.2.1 CCB and health promotion

CCB is regularly used within the health promotion field as an effective method for successful creation of health-related initiatives. Labonte and his colleagues argue that integrating CCB into health promotion programs adds parallel outcome measures (capacity outcomes and program specific outcomes), challenges workers to more critically examine how they are building a community’s capacities, challenges institutions to be accountable to community groups, and can multiply the intended health gains by making programs more effective (Labonte et al., 2002). In an Australian study on reducing unhealthy weight gain in children through CCB, researchers found a CCB approach to be a “flexible, cost effective, sustainable, equitable and safe”

approach to reducing childhood obesity. A study completed by Raeburn, Akerman, Chuengsatiansup, Mejia, and Olandepo in 2006 examined five separate case studies showing the range and efficacy of the application of CCB in health promotion projects. The authors argued that “the potential of human capacity at the community level cannot be underestimated, when people work together on common goals” (Raeburn, Akerman, Chuengsatiansup, Mejia, & Oladepo, p. 89, 2006). The potential of CCB to aid in successful implementation of health promotion programs has been successfully tested world wide, in a variety of settings and on many populations, including smaller scale institutionalized settings, and with the aging population (Kaplan, Liu, & Hannon, 2006; Raeburn et al., 2006; Spoth, Greenberg, Bierman, & Redmond, 2004).

1.2.2 CCB, institutionalized settings, and older adults

CCB projects are commonly used to target a broad geographical location. However, CCB projects can also target smaller entities, identified by a group of people with common needs, tasks or interests (Verity, 2007). Kaplan et al. (2006) demonstrated this in their report on the implementation and evaluation of an intergenerational program at a continuing care retirement community (CCRC) that used a CCB approach. The first step in their work was to describe the context within which the project took place. Next, they identified local children and youth programs using what they referred to as “intergenerational options mapping”. They then initiated dialogue between administrators from these programs and the CCRC, and finally, they developed partnerships with organizations who expressed interest and shared mutual objectives. The staff and residents reported their community partners to be a useful way to establish flexible and diverse programs for both the residents and youth, with documented benefits for both age groups (Kaplan et al., 2006). The Australian *Stay on Your Feet Falls Prevention Program* is an example of an initiative using CCB concepts to target the older adult population on both large and small scales, as this program has been introduced at retirement homes and in communities around the world (van Beurden, Kempton, Sladden, & Garner, 1998). Common among these examples, and many other CCB projects (e.g., Spoth et al., 2004; Wescott, 2002), is the use of partnerships within a community to help build capacity.

1.2.3 CCB and partnerships

According to Crisp, Swerissen and Duckett (2000), a partnership approach to CCB requires that relationships between organizations or groups of people be strengthened. The authors state that “this approach is based on the assumption that “providing possibilities for the two-way flow of knowledge can lead to partnerships through which the resources required to plan and implement health programs may emerge” (Crisp, Swerissen, & Duckett, p. 102, 2000). Furthermore, it is important when forming partnerships to look for functional and mutually beneficial relationships. An example of a mutually beneficial partnership that has been used in CCB projects is between communities and local schools. Kretzmann (1993) described the resources local schools can bring to a CCB initiative and the importance of partnerships being mutually beneficial. The positive results that can come from capacity building partnerships with local schools was demonstrated in a 12-year youth and family competence-building project. This project presented a partnership model that used a linking system/team to maintain information flow between the two partners. This model was used to guide capacity building in education systems, for the delivery of evidence-based family and youth interventions. The partnerships were initiated through local university efforts to identify appropriate state-level and community partners for implementation of the interventions (Spoth et al., 2004). Three elements identified for the creation of successful partnerships in CCB include: complementarity and fit of partners for shared knowledge and mutual benefit, diversity of activities to attract a variety of partners and extend the network reach, and a sufficient collaboration-time period to build relationships and obtain results (Marlier et al., 2015). Additionally, the use of partnerships within a CCB strategy has also been used in settings where communities are impoverished and have minimal financial resources (e.g., Moreno, Noguchi, & Harder, 2017; Raeburn et al., 2006).

1.2.4 An economical and sustainable approach

As it is difficult to sustain health promotion projects once initial funding runs out, CCB is regularly suggested as a means to promote sustainability (Gibbon et al., 2002; Labonte & Laverack, 2001a; Provan, Nakama, Veazie, Teufel-Shone, & Huddleston, 2003). The

view that by working together, community organizations can coordinate efforts to maximize information and share expertise, using minimal resources, is prevalent in the CCB literature (Labonte & Laverack, 2001b; Provan et al., 2003; Raeburn et al., 2006). This reliance on a community's own resources, instead of outside external funding, is evident as a key to success and sustainability in five case studies outlined in Raeburn et al.'s (2006) paper on CCB and health promotion. The cases occurred in underdeveloped areas in South America and Africa, all with limited access to external resources, leaving them to rely on their community strengths for long-term success (Raeburn et al., 2006). Shediac-Rizkallah and Bone (1998) specify that when planning for sustainability, a clear understanding of operational indicators used to monitor sustainability must be considered. One of the three indicators of sustainability described is "measures of capacity building in the recipient community" (Shediac-Rizkallah & Bone, p. 87, 1998). These authors highlighted that CCB follows the rationalization that increasing community participation, increases community ownership, which then leads to increased capacity and program sustainability (Shediac-Rizkallah & Bone, 1998). The focus on CCB as a dynamic concept or cycle, that never truly ends, in itself implies long-term sustainability (Baillie et al., 2008; Goodman et al., 1998; Labonte & Laverack, 2001b; Moreno et al., 2017; Raeburn et al., 2006; Verity, 2007). The forming of reciprocally beneficial partnerships further adds to capacity and sustainability, as programs can become embedded within wider community initiatives (Moyer, Coristine, MacLean, & Meyer, 1999). Further adding to sustainability is the reliance on internal resources as opposed to external ones that will likely run out, as the means, resources, know-how, contacts, and drive to maintain various projects is being provided by the community (i.e. improved physical activity) (Jackson et al., 1994; Kaplan et al., 2006; Labonte & Laverack, 2001b). Another key to sustaining projects and programs is promoting community empowerment (Jackson et al., 1994).

1.2.5 CCB and empowerment

Increasing community capacity, partnerships, and empowerment of individuals are all priorities outlined by the World Health Organization in the 1997 Jakarta Declaration for health promotion in the 21st century (World Health Organization, 1997a). Empowerment

involves enhancing “the possibilities for people to control their own lives” (Rappaport, p. 15, 1981). In health promotion it refers to “a process leading to enhanced control by community members of the resources, decisions, structures and other factors affecting their health” (Jackson et al., p. 394, 1994). In order to achieve this, the characteristic dynamic relationship between professionals and community members needs to be broken down, and development of collaborative partnerships must replace it (Jackson et al., 1994; Rappaport, 1981). As a foundational concept, CCB has evolved from the notion of community empowerment, with the main goal of increased self-determination, self-esteem and empowerment, now becoming one of many positive outcomes of CCB programs (Gibbon et al., 2002; Laverack, 2006). In fact, much like sustainability, community empowerment is often implied when using CCB, as the two terms have often been used interchangeably (Gibbon et al., 2002; Labonte, 1993; Labonte & Laverack, 2001a). By focusing on a community’s strengths and how to develop and use those strengths, CCB is able to empower communities, organizations, and individuals (Beaulieu, 2002; Rappaport, 1981; Smith, Littlejohns, & Thompson, 2001; Verity, 2007).This is aptly displayed in the case studies outlined by Raeburn et al. (2006). CCB projects focused on the utilization of local talents, contribute to a sense of empowerment, as those involved feel as though they have contributed something of value (Beaulieu, 2002). An approach that has developed from this idea, is asset-based CCB, which has been contrasted with a needs-based approach (Kretzmann & McKnight, 1993).

1.2.6 An asset-based approach to CCB

An asset-based approach to capacity building focuses on community strengths/assets, building interdependencies, identifying how people can help, and seeks to empower people; in other words, it is asset-based, internally focused, and relationship driven (Beaulieu, 2002; Kretzmann & McKnight, 1993). Contrary to this method, a needs-based approach focuses on deficiencies, provides fragmented responses to needs, creates dependencies on services, and gives power to “outside help”, all contributing to a focus on deficiency and creation of a reliant community (Beaulieu, 2002). The

potential for growth and focus on strengths, empowerment, and sustainability promoted by an asset-based approach were the reasons it was chosen for this study.

An asset-based approach begins with a belief that all people, no matter their age, gender, race, etc., can be resources and can contribute to building a community's capacity. Asset mapping encourages local people and organizations to explore how problems may be interrelated and how to respond in a "coordinated, collaborative fashion" (Beaulieu, p.4, 2002). The definition of community is fluid and varies with CCB projects (Verity, 2007), for the present study the immediate community refers to the retirement home residents and staff. This then expands to include the surrounding community as well, as identified assets are introduced. An asset-based approach utilizes the following steps to understand a community's assets, and to develop partnerships and strategies to address the problem at hand. Beginning with an inventory of individuals, organizations, and institutions, this step helps to collect preliminary information on existing resources, leadership, and intelligence within the community, the key building blocks of CCB in Baillie et al.'s (2008) framework. Asset mapping further adds to the depth of this information, highlighting useful resources with which to connect. The last steps involve building relationships and mobilizing assets. As CCB is a continuous process, these steps can cycle again as an updated inventory of assets must be maintained for capacity to continue to grow and as communities change (Baillie et al., 2008; Beaulieu, 2002). The study described below explains how the capacity building asset-based approach was utilized and the recommendations for change that ensued to improve the physical activity options provided at the retirement home.

Chapter 2

2 Methods

In keeping with the idea that CCB projects often vary (Mathie & Cunningham, 2003) and that each project must be somewhat methodologically flexible (Kaplan et al., 2006), the present study synthesized methods from sources reviewed above, but followed an asset-based philosophy and approach, as outlined below. More specifically, Baillie et al.'s (2008) framework, in particular the three key building blocks of capacity building,

was amalgamated with methods described by Kapalan et al. (2006), Beaulieu (2002), and Kretzmann and McKnight (1993).

2.1 Context

As this was a quality assurance project according to Western University REB protocol, ethics review was not required under assumption that guidelines for anonymity, confidentiality, and respect were maintained. (see checklist, https://www.uwo.ca/research/_docs/ethics/hsreb_guidelines/HSREB%20Guidance%20-%20Distinguishing%20Between%20QA%20and%20Research%2029May15.pdf). The first major step in the present project was to understand the context within which the problem (i.e.,to improve the physical activity choices for the residents of the home) was set. In keeping with the definition for “community”, this meant gathering information on the home, its people, and the surrounding geographic area. Although this step is often implicit in asset-based CCB projects, the circumstances of this project required care to be taken to ensure a complete understanding of the context. Following the steps taken by Kaplan et al. (2006), observation, conversations, and information sources were used to form a better understanding of the context.

2.1.1 Understanding the home

Before an onsite visit, online searches to gain information on the company owning the home and the home itself were completed. The company website (not provided here for anonymity) was reviewed to determine: company structure; company size; financial structure; management structure; values, mission statements, and goals; and current program standards. This information was expanded on while visiting the home to confirm that the home’s environment did in fact match their described mission and values. Information on home specific rent costs, management roles and other such information that could not be found online was obtained directly from the general manager (GM). Clarification on home specific details was provided and notes were taken on the information provided by the GM (see field notes in Appendix A).

2.1.2 Understanding the residents and staff in the home

As arranged by the GM, the first step was an introduction to the management team. Importantly, this included the Health and Wellness Manager responsible for ensuring residents enjoy a lifestyle and quality of life that exceeds their expectations, nurses who regularly interact with residents and can impact care, the Maintenance Manager who was responsible for maintaining spaces and equipment that could impact physical activities, and the Lifestyle Program Manager (was not present, introduced over the phone) who was responsible for development and coordination of programs and services to meet activity needs of residents (including physical activity). The next step was to observe normal day-to-day operations. For seven days, 6-8 hours each day was spent at the home, attending daily activities, meal times, and taking periodic walks through the home between planned activities. While observing at the home, informal conversations with staff, residents, family members, and volunteers were also conducted.

Residents (on two occasions family members were present with the residents) were approached when they appeared to be available. A list of all residents was provided by the nurse, who highlighted those residents with dementia, are in significant pain, and/or do not participate often. An attempt was made to speak with a variety of residents (i.e., residents with dementia, less social residents, wheel chair bound residents, residents who had recently moved in, longer-term residents, etc.), although these attempts were not always successful as residents sometimes refused to converse. Those who agreed were informed of the purpose for the visit (e.g., “Hello, my name is _____. I am a university student looking at the physical activity in the retirement home. Do you mind having a conversation with me?”). Approximately 25% of the resident population (n=16) agreed. They were then asked some or all of the following questions depending on the direction of responses: how long have you/your relative been living at this home? What do you/your relative enjoy doing? What did you/your relative enjoy doing before living at the home? What barriers prevent you/your relative from participating in activities you/they enjoy? What would you/your relative do if those barriers could be removed? Staff and volunteers were asked about normal resident activity levels, popular activities,

physical activity attendance, what barriers they thought residents might face, and how they thought the home could improve. During this time, resident demographic information was obtained from the GM, as well as observation of day-to-day activity while attending meal time, activities, staff meetings and physical activity classes. Observations and answers to questions posed were recorded in field notes that can be found in Appendix A.

2.1.3 Understanding the community at large

This information collection began with a Google map search of the city and a general search online, on Statistics Canada (http://www.statcan.gc.ca/eng/start) and the city websites (websites not provided for anonymity), to determine city demographics. This provided a better understanding of the size and spread of the city as well as the location of potential resources such as educational institutions, organizations, malls, community centers, parks, trails, etc. Searches on the city website also aided in exploration of city infrastructure and resources potentially connected to physical activity and physical activity programs (e.g., YMCA), especially those in close proximity to the retirement home. On several occasions, the present researcher used the city transit system and this provided insight on its efficacy and provided a good 'tour' of the city, the ease of traveling through the city, and what infrastructure and resources could be easily accessed when using transit.

2.2 Asset mapping

The understanding of the context was used to inform choices of assets to be mapped both within and outside of the home. The assets were catalogued using Ballie et al.'s key elements for capacity building: leadership, resourcing and intelligence. For the present work, leadership was defined as those people who could influence the actions to be taken (i.e., developing physical activity choices). Resourcing referred to the human (skill and knowledge) and physical resources (i.e., those things required for action to take place). Intelligence referred to the experience and practical wisdom that could inform the process and recommendations to be made. For example, if volunteers entered the home, did the staff in the home or community leaders have experience at

facilitating this process in some way themselves. Or, what experiences (e.g., gardening) did the residents have that could facilitate activity program development.

2.2.1 Internal assets

The internal assets of the home were identified first. The assets were considered based on their ability to support Baillie et al.'s key CCB elements, leadership, resourcing, or intelligence. This involved creating a catalogue of information gained through observation and conversations at the home. The aim was to catalogue the internal assets that could contribute to achieving the goal of a quality improvement process to increase physical activity choices and attendance.

2.2.1.1 Leadership

To identify individuals who could fill internal leadership positions, both staff and residents were considered as possibilities. Consideration of current staff roles and responsibilities in particular as connected to resident physical activity were used to identify possible leaders who were then approached and questioned (e.g., Lifestyle Program Manager roles considered more relevant to the goal than Sales Manager). Those approached included the GM, the Lifestyle Program Manager, the Health and Wellness Manager, and the nurse working that week. The questioning was used to determine their 'buy-in' or belief in a need for change, and their willingness to take on additional and/or altered responsibilities. Residents were identified based on their current and past participation in activities and social interactions with staff and other residents (based on information gained from the initial conversations with staff, residents, and family, or from observation). In total, five residents were approached and similar questions were asked.

2.2.1.2 Resourcing

This information was gained through examining current staff roles and responsibilities (e.g., the Lifestyle Program Manager, with a background in Recreation Therapy, has obvious skill and knowledge related to enabling physical activity), and conversations with both staff and residents. Answers to questions concerning previous preferred

activity and current activity were considered when identifying residents with relevant skill and knowledge.

The physical resources within the home were explored to determine utilization in enabling a variety of physical activities. Resources such as space and equipment were all considered useful assets that could be effectively allocated to achieve the stated goal. These were identified by touring the residence and recording lists of everything that could help to facilitate activity.

2.2.1.3 Intelligence

To identify relevant intelligence, an understanding of people's backgrounds and experiences were required. To determine this, again the conversations with residents and staff were used. For example, a resident who used to enjoy gardening would be considered to have experience to help to inform and facilitate a gardening program. This past experience was gathered while reviewing the field notes from earlier conversations. Another example of intelligence was the capacity of the Lifestyle Program Manager to schedule, advertise, and administer an activity to target all ages and abilities.

2.2.2 External assets

Upon completing a map of the internal assets, outside organizations and institutions were then considered. By getting to know the community, its skills, and key areas of employment/business/activity/vitality, relevant resources were identified and the appropriate people/organizations approached (Beaulieu, 2002). Inventories of local formal and informal organizations, groups, and institutions were completed based on Beaulieu's (2002) asset mapping inventory guide. All organizations and institutions identified in the context description as potential aids to improved physical activity were contacted so that further information could be gathered. A first step was to search organizational websites to determine whether they had a physical activity program (appropriate for the residents) or a program that could be linked to physical activities to be offered. The next step was to locate contact information for a subject matter expert (SME) in the organization who could explain the organization's programs. Followed by contacting the identified SME to collect further details of the program that was identified

as linked to physical activities. The SMEs were informed of the purpose for which they were being contacted and asked if they would explain the program further, how it was implemented, and how, why and when it was created. Questioning (more than one contact and meeting were sometimes necessary) was deemed complete when sufficient information about leadership, skill, knowledge, and intelligence/experience was gained.

2.2.2.1 Leadership

Leadership within the external assets was identified based on individuals' influence within an organization, institution or group (i.e., a company CEO would have significant influence) that could help to improve physical activity offerings at the home. These people were identified by searching their websites for contact information. If this could not be found online, phone calls were made to people associated with the asset. The goal was to determine if there was someone influential within their structure who could be an asset to help achieve improved physical activity choices at the home. The names and information were recorded for future contact to arrange meetings if deemed a potential beneficial partner during the analysis.

2.2.2.2 Resourcing

The skills and knowledge of the people (i.e., human resources) within external assets were determined through contact with the institutions/people associated with the asset. The skills and knowledge were gained from interviews and/or written documents on their websites; looking at or asking about individuals areas of expertise. The goal was to determine what skills and knowledge they possessed that would enable improved physical activity choices and support change in the home. The physical resources were identified through conversations with people or organizations identified as possessing useful skills and knowledge that might lead them to having useful physical resources to facilitate physical activity (e.g., a YMCA with a seniors' program has trainers with transportable equipment).

2.2.2.3 Intelligence

The practical wisdom and experience provided by external assets was identified when considering the purpose behind the identified asset. This information was gained through contact with organizations and/or institutions. For example, an organization that provided a service in senior living in the past, or an organization that facilitated physical activity for older adults in the past, would have relevant practical experience. The intelligence a potential asset could provide was considered valuable if it could help with the process of introducing further physical activity choices at the home.

2.3 Partnership Analysis

The inventory of assets that resulted from the mapping process was then analysed to determine the full scope of resources available to help achieve improved physical activity choices and participation at the home. This was done for both internal and external assets identified, using the asset maps and information in field notes, and looking for leadership, resourcing, and intelligence. Analysis of the asset maps was performed with the authors' supervisor. As well, the external assets were analysed to determine the feasibility of a partnership with the institutions and organizations identified as potential external assets. The asset maps were read looking for leadership, skills and knowledge, and intelligence that each resource or potential partner could bring, and whether mutual benefit would be likely (Kaplan et al., 2006; Kretzmann & McKnight, 1993; National Center for Injury Prevention and Control, 2008). Additionally, the external assets were considered for their feasibility to support the desired physical activity outcomes with the already identified internal assets available. Those recognized as being able to contribute to mutually beneficial problem solving were then contacted to begin developing partnerships.

When contacted again, the individuals (those identified as potential leaders within the organization) were given further information regarding the reason they were being contacted. This included both further background on the nature of the project (i.e., looking to form mutually beneficial partnerships within the community to improve physical activity choices available at the home) and what was believed they could

provide to the home and what the home could provide for them. Also, essential to acquiring skills and knowledge from assets was confirming their willingness to share their skills and knowledge and establishing their belief in the proposed changes being implemented. In-person meetings took place at various identified institutions. Further information sharing and clarification on the benefits of engaging in a partnership were outlined and details of the partnership were discussed.

Chapter 3

3 Results

3.1 Context

3.1.1 Understanding the home

This retirement home advertised independent, supportive living for older adults in a single-story building. The home was located in a residential area in a Northern Ontario city. It was a for-profit home that promoted active, engaged and secure living for all residents. According to the company's website, their vision was to make peoples' lives better. Their mission was to provide a happier, healthier and more fulfilling life experience for seniors, to provide peace of mind for residents' loved ones, and to attract and retain employees who care about making a difference in residents' lives. Their core values included respect, empathy, service excellence, performance, education, commitment, and trust. The company performed yearly resident satisfaction surveys at all homes across Canada and this home ranked highest in resident satisfaction in 2015.

The home's main source of income was the monthly accommodation fee which paid for a room, 24-hour staff (i.e., personal support workers), regular observation of well-being via weight and blood pressure clinics under the supervision of a nurse and the Wellness Manager, monthly activity calendars, and gentle exercise classes offered three days per week. For an additional cost, residents could receive services such as medication management, customized care, assistance with activities of daily living, etc., depending on individual needs.

The company offered signature programing at all their residences that brought together six dimensions of wellness: physical, social, intellectual, emotional, spiritual, and vocational pursuits. Physical activity was promoted at the home to maintain health, independence, and quality of life. This home offered gentle exercise classes three days per week. The classes were run by a physiotherapist assistant who sometimes brought additional equipment such as resistant bands. Other physical activities offered at the home included a signature Rhythm N' Moves class which incorporated music and movement, and a falls prevention program offered twice per week (funded by the Ontario Government, but not guaranteed indefinitely). In addition to these programs, there were signs around the home promoting 30 minutes of exercise be performed each day for optimal health, and suggestions on the activity calendar that residents go for walks on weekends when less organized activities were planned.

3.1.2 Understanding the residents and staff in the home

There were 65 residents living at the home, 74% of whom were female. The average age of the residents was 85 years, ranging from 65 to 98 years of age. A large portion of the residents were widows or widowers (~85%) and three quarters of the residents used a walker or some other kind of assistive device such as a cane to move around. A table of resident demographics can be found in Appendix B.

Importantly, the management team included the General Manager, Lifestyle Program Manager, Health and Wellness Manager, and Maintenance Manager whose job descriptions were provided by the GM. The GM was responsible for the overall operation of the residence, including: resident care, programs, services, environmental coordination and fiscal performance. The GM was also responsible for the creation and operation of a retirement residence where residents "enjoy a lifestyle and quality of life exceeding their expectations". The Lifestyle Program Manager was responsible for developing and coordinating programs and services that met all residents social, physical, intellectual, vocational, emotional, and spiritual needs, but was only present onsite for three days (20-hours) each week. The Health and Wellness Manager was responsible for ensuring residents "enjoy a lifestyle and quality of life that exceeds their expectations". The Maintenance Manager was responsible for the general maintenance,

servicing, and repair operations required to maintain the residence, equipment, furnishing, fixtures and surrounding grounds. As well, the care team included a nurse, who regularly interacted with residents and was responsible for providing care in accordance with residents required medical care and established care plans.

Conversations with residents, family members, staff, and volunteers uncovered additional information which is summarized in Table 1.

Table 1: *Summarized Conversation Information*

Topic of Information	Summarized Answers
Past activities in which residents participated	reading, gardening, baking, cooking, scouting, knitting, video games, hymn sings, music, dancing, being physically active, walking/hiking, camping, shoveling snow, caring for children, being with family
Barriers to participating in activities residents enjoy	Day-to-day health, weather, pain, lack of motivation, lack of resources, lack of interest, bad previous experiences, timing of activities, memory problems, lack of transportation, lack of money
What would happen if barriers were removed	With some encouragement, might pick up old hobbies or activities; would be more willing to participate and engage; would provide more input into what they would like to see offered
The most popular activities offered at the home	Birthday parties (with dancing), weight and blood pressure clinics, bean bag toss game, professional presentations, outings, anything with food
Activities residents would like to see offered	Horse shoes, more outdoor activities, raised gardening, creation of a resident cook book, waterfront trips, YMCA memberships (to swim and see kids), trip to local conservation area

3.1.3 Understanding the community at large

According to Statistics Canada, the median age in this city was higher than both provincial and national averages and 17% of the population was over the age of 65, compared to a national average of 14.8%. The home was a five-minute drive or less from the downtown core, a mall, parks, trails, community centres (YMCA), paved paths, and a 50+ activity club for older adults. The waterfront was well maintained, with parks, paved walkways, benches, and other attractions. The city was home to multiple high schools, a university and college, and the transit system was able to transport all people (i.e., seniors, wheelchair bound, etc.) to major resources throughout the city, such as the mall, downtown, and schools. The distances to the identified potential resources from the retirement home are shown below in Figure 1, all of which were accessible by transit.

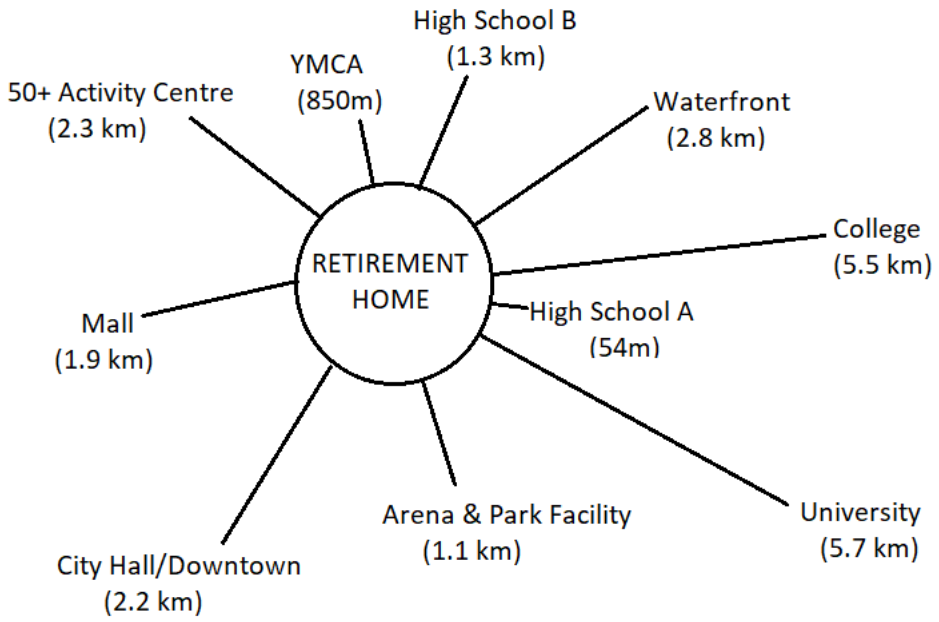

***Figure 1*: Map illustrating potential resources identified in the community and their distances from the retirement home.**

3.2 Internal assets

The internal assets identified are summarized in Table 2. Each asset is broken down by the leadership, resourcing (skill and knowledge), and intelligence/experience that they provide that could support physical activity offerings at the home. An important focus for this process and future internal asset mapping was on the experience residents might provide. This experience could support future physical activities to be offered (all physical resources can be found in Table 4 below).

Table 2: *Identified Internal Assets*

Person	Leadership	Resourcing: Skills & Knowledge	Intelligence/ Experience
General Manager	In charge of quality assurance within the home and recognizes the need to make changes that will increase the physical activity and well-being of residents	Leadership and management skills; knowledge of the senior populations needs; knowledge of company policies	5+ years experience working in senior living; prior partnership experience; experience hosting volunteers and students in home
Health and Wellness Manager & nurse	Has influence over recommendations for maintenance of health and quality of life of residents	Trained as a nurse; skills in assessing, planning, implementing and evaluating care for residents	Prior experience caring for older adults, recommending lifestyle changes to improve quality of life, and assisting in the lifestyle change process
Lifestyle Program Manager	In charge of all program planning and content for residents	Trained as a recreation therapist who can properly assess, plan and deliver activities for those with illness or disability	Has previous experience supervising volunteers and students; 3+ years of experience with program delivery process for older adults

Family member 1	Has influence on residents, often inviting their loved one and others out of their rooms to play games and visit	To be determined	Past experience motivating their family member and other older adults
Resident A	Always looking to do something and reaching out to other residents to do things with	Knowledge of the importance of physical activity with aging	Past experience walking paths around the home
Resident B	Has influence over friends/other residents within the home	Lived on a farm for most of his/her life, gaining skills and knowledge related to proper garden and crop	Past experience caring for large gardens and crops
Resident C + D	Have large influence over each other, often only participating when encouraged to do so by their significant other; influence on friends/other residents	Both will have knowledge of the physical abilities, limitations, interests, and health concerns of their significant other; Resident C use to be a piano teacher	Experience teaching piano and instructing/ encouraging others constructively
Resident E	Influence over friends/other residents	Trained ballroom dancer	Experience teaching choreographed dance and instructing/ encouraging others constructively
Resident F	Influence over friends/other residents	Trained piano teacher	Experience teaching piano, performing for audiences, and

			instructing/ encouraging others constructively
Physiotherapy Agency	Physiotherapists and physiotherapists assistants have influence on exercise completed by residents who attend classes and those visited in their room for therapy	Trained in anatomy and physiology, function and movement, and proper administration of exercises for seniors for therapeutic and rehabilitative purposes	Experience determining, prescribing, and leading the appropriate intensity, type and time for exercises for older adults with varying degrees of ability

Note. Leadership refers to those individuals identified as having influence over the development of physical activity choices. Resourcing: Skills & Knowledge refers to human resources that should help to enable action to take place to improve the physical activities offered. Intelligence refers to practical experience and wisdom that should inform the process of improving the physical activities offered.

All the internal assets identified were considered significant as these assets were directly accessible and have no additional financial cost. The internal assets could also have direct empowerment and capacity building effects as the home is identifying their strengths and contributing to the process of improving physical activity offerings. It will be an important map to update and maintain regularly (e.g., as residents or staff change).

3.3 External assets

The identified external assets are summarized in Table 3. Like the internal assets, they are broken down based on the leadership, skill and knowledge resources, and intelligence/experience that they could provide that would support physical activity offerings at the retirement home (all physical resources can be found in Table 4).

Table 3: *Identified External Assets*

Institution/ Organization	Leadership	Resourcing: Skill & Knowledge	Intelligence/ Experience

Secondary School A	Co-op supervisor's job to place 30+ students (depending on enrollment) in placement position that fits the students and various organizations best interests. Influence on what student is placed where, must approve work schedule made between student and organization, and lead in-class portion.	Secondary students in grades 11 and 12, with various skills depending on interests, to be placed in an appropriate atmosphere to enhance their learning and help improve physical activities offered at home. (e.g., a student background and interest in computers can work on promotional posters or student interested in physiotherapy can help with exercise classes)	Experience with the process of placing students in appropriate environment to maximize learning and work experience; must understand placement process including police check requirements, organization expectations, school expectations, and student expectations
Secondary School B	Co-op supervisor's job to place 30+ students (depending on enrollment) in placement position that fits the students and organizations best interests. Influence on what student is placed where, must approve work schedule made between student and organization, and lead in-class portion.	Secondary students in grades 11 and 12, with various skills depending on interests, to be placed in an appropriate atmosphere to enhance their learning and help improve physical activities offered at home. (e.g., a student background and interest in computers can work on promotional posters or student interested in physiotherapy can help with exercise classes)	Experience with the process of placing students in appropriate environment to maximize learning and work experience; must understand placement process including police check requirements, organization expectations, school expectations, and student expectations
College (Recreation Therapy Program)	Program coordinator and teacher, manages 50 + students throughout the semester, makes decisions concerning where students can complete required placement, and ensures	Students learn to assess, plan and deliver activities for those with illness or disability with an aim of improving the individual's quality of life; students required to complete an assessment course second year and a	Coordinator is familiar with the process of placing students at organizations within the community; evaluates student work in the field with expectation that they apply the appropriate

	effective hands on application of course material can take place	programing course, with skills and knowledge which they can directly apply while working with the home	knowledge, skills, and processes; Understands the requirements and expectations organizations have of students and the school itself.
University (Physical and Health Education Program)	Community placement coordinator arranges placement positions with community organizations that align with students' fields of interests; places 50+ students in the community for the organizations and students' best interests; ensure effective work experience is gained that aligns with the students interests and that all required work is completed	Students will be placed based on their sector (allied health/clinical, physical and health education, health promotion, sports marketing/sport event management, coaching/training, and fitness and wellness). This will determine the specific skills and knowledge that they bring	Placement coordinator is familiar with the process of placing students at organizations that align with students and organizations interests; understand the requirements and expectations organizations have of students and the school itself.
50 + Activity Centre	The club is associated with the United Senior Citizens of Ontario and the Older Adult Centres' Association of Ontario. The club is a leader in connecting the local 50+ community with the larger community, bringing in and connecting people with useful resources, services, and programs	It is governed by a volunteer Board of Directors and administered by an Office Manager with the help of many community volunteers and 'experts' who use their knowledge and skill to help run programs, such as dancing, tai chi, and exercise classes for older adults	All administrators and volunteers will have experiences with the process of successfully delivering programs to older adults, with varying degrees of ability and interests

	provided by trained community volunteers		
YMCA Community Centre	Employs multiple instructors who will have influence over individuals who attend their seniors' classes and activities	Instructors will have the skills and knowledge required to lead various physical activities	YMCA management will have experience providing physical activity services to a variety of age groups and what is required to do so in an effective and efficient way
City Hall	The city is working to become a WHO classified Age Friendly city and will have numerous people and partners working to ensure the necessary changes and adjustments are being made throughout the city to achieve this classification.	Those working on the project will have the knowledge required related to the needs and wants of older adults and what services and skills will need to be accessible in order to achieve Age Friendly city classification	The city will have experience implementing numerous projects, big and small, to inform process of making appropriate physical and procedural changes to achieve stated goals

Note. Leadership refers to those individuals identified as having influence over individuals of the organization/institution and/or the development of physical activity choices. Resourcing: Skills & Knowledge refers to human resources that should help to enable action to take place to improve the physical activities offered. Intelligence refers to practical experience and wisdom that should inform the process of improving the physical activities offered.

The educational institutions provided a promising option for potential partners as they would be more likely to have minimal financial requirements involved, compared to the YMCA or 50+ Activity Centre (although the costs associated with the activity centre were minor). The school partnerships also offered an almost unlimited source of in-kind services which Baillie et al. (2008) recognized as a valuable building block. Additionally,

the option to promote intergenerational interaction among students and seniors made partnering with educational institutions a valuable opportunity to pursue.

3.4 Physical resources

The identified physical resources are summarized in Table 4. These assets were identified for their ability to facilitate physical activities for the retirement home residents. The table includes the physical resources identified both internally at the home and externally in the community.

Table 4: *Identified Physical Resources*

Source	Physical Resources
Internal	T*rails* right outside home are apart of the major paved path system that extends through much of the city.
	Surrounding the home there are *gardens, a patio, and a gazebo* with plenty of *space* for outdoor activities
	The dining room provides sufficient *space* as it is the largest room in the home, when needed it is cleared and used for parties, dancing, and other events
	The room used for exercise is located at the front of the home and is a large enough *space* to hold 10 - 15 residents and chairs comfortably. Chairs typically arranged in the middle of the room with a piano and a CD player for music at the front
	Stationary bikes are in the activity room which also holds the library, a bean bag game, book shelves and other activities.
	At the time of the first visit, the home was in the process of purchasing *a bus* for resident transportation
	Hand rails in the hall ways can provide an extra support for residents while walking or performing exercises required balance
External	Two major *trail systems* meet, totalling 17.5 km of *paved parallel walking path*s that traverse a large portion of the city, including the waterfront and passing by the retirement home.
	The waterfront, accessible from downtown, has 2 miles of *paved walkways* with ample parking, an arboretum, marina, picnic tables and shelters, benches, and playgrounds

	The 275, 000 square foot mall promotes an active lifestyle, with adequate *space* for regular walking groups and plenty of seats and benches
	The YMCA facility has a *exercise gym, pool, gymnasiums/courts, and ample equipment* for various games, activities, and sports.
	Near by parks provide a large *space* for a variety of physical activities to occur

The physical resources identified would all be useful in enabling physical activity and providing options for residents. The variety of resources available would help to target all resident interests and abilities. All the internal resources identified would help to enable physical activities in the home. Those identified externally within a close distance would prove more valuable than those less easily accessible. This list would also change regularly and should be maintained as partnerships are formed and their resources are made available.

3.5 Potential partnerships

After consideration of the external assets, four educational institutions/programs were identified as the most feasible partnerships (providing leadership, skill, knowledge, intelligence, and mutual benefit): the college Recreation Therapy program, the university's Community Leadership Placement program, and two high school Cooperative Education programs. Since the home was looking for a low budget option and currently only had the Lifestyle Program Manager present three days each week, these partnerships would aid in keeping costs low while partnering with valuable leadership, resourcing, and intelligence from both the home and the schools. The partnerships with each institution are described below.

3.5.1 College Recreation Therapy Program

This program would provide leadership in the form of the college program coordinator who agreed to partner the program with the retirement home. The students would use their skill and knowledge learned in the program to facilitate physical activities at the home. The program coordinator's experience forming partnerships with other organizations and facilitating this program would provide useful intelligence to inform the

process. The home would benefit from the leadership, knowledge, skill, and intelligence that the college program would bring to the partnership (at no extra cost), and the college would benefit from the hands-on learning experiences provided to students working with the retirement home.

Over a two-year period, these students learn to properly assess, plan and deliver activities for those with illness or disability, with a goal of improving quality of life. During their program, students must complete a hands-on placement (280 hours) and a practicum (100 hours), both representing significant in-kind resources for the partnership. Before beginning work in the community, students would be required to discuss their goals with their placement supervisor at the college and create a list of specific goals with their placement site supervisor so that expectations are clear among all parties. The first semester (September – December) would include an assessment course in which students would learn to assess individuals to determine their recreational and leisure needs. The course typically has about 30-40 second year students who would benefit from hands on application of the material they would be learning in the course. This would also benefit the home and its residents as the home would gain more individualized information on each resident. This information would help improve the physical activities offered and potentially appeal to more residents. The second semester (January – April) includes a leadership and program planning course for first year students. This course teaches students to effectively plan and lead programs for a variety of populations with varying abilities. These students would be able to apply the material they are learning in class to develop physical activities based on the information gained from the first semester students' assessments. While working at the home, the students would be covered by the college insurance policy. In addition to school required tasks that must be completed prior to beginning, the home requires all students to have a vulnerable sectors police check and a 2-step TB test* prior to working at the home (*required of all volunteers).

3.5.2 University Physical and Health Education Community Placement Program

The university program coordinator would provide leadership and intelligence in support of the partnership and process of placing students at the retirement home. The students would provide knowledge and skill that would help to inform the physical activities offered at the home. The school would benefit from their students gaining hands-on experience while working at the retirement home and the home would benefit from the leadership, skill, knowledge, and intelligence that the school could provide.

This 4-year degree prepares students to become leaders in the promotion of healthy, active lifestyles for all ages. The program includes a 50-hour per year community leadership placement for 3rd and 4th year students. The placements are assigned by sector, which include: allied health/clinical; physical and health education; health promotion; sports marketing/sport event management; coaching/training; and fitness and wellness and can occur anytime from September to April. The 3rd year students are assigned a placement based on their top choices of options provided by the university. Additionally, for 4th year students, there is an option to complete placement hours over the summer. This could help to maintain a student presence at the retirement home all year. All students are required to provide the university Placement Coordinator with a proposed work schedule, determined with their placement supervisor (i.e., the lifestyle program manager or GM at the retirement home). The school requires the supervisor at the home to sign forms at the start of a placement, sign off on student's hours, and complete an evaluation of the student at the end of the placement. The students are required to sign an insurance release form, complete a workplace safety module, and provide proof of certification in CPR Level C and Standard First Aid prior to beginning their placements. Again, the home requires a 2-step TB test and vulnerable sectors police check before beginning placement at the home.

3.5.3 Secondary School Cooperative Education (Co-op) Programs

The high school co-op program coordinators would provide leadership through their influence on the students and the co-op program, and intelligence through their

experience of facilitating the program and placing students within the community. The students would provide a variety of skills and knowledge that they have learned in school to facilitate physical activities offered at the home. The home would benefit from the school's in-kind contributions, leadership, skill, knowledge, and intelligence, while the students would benefit from real life work experience.

With this partnership, students would be present full or half days from Monday to Friday, for a total 110 hours over their school year (September to June inclusive). Students are required to complete preplacement class work for two weeks, in addition to one in-class day each month for assignments**.** It was emphasised by the school coordinators that the tasks of the students would be more widespread due to a variety of interests students might have (i.e., student could do more computer work or more hands on, building work). While at their placement location, the students would require a supervisor to report to and check in with each day. It was explained that the relationship between the on-site supervisor, co-op coordinator, and student must be very open and transparent, and would include unscheduled drop-ins by co-op coordinators at placement sites to check on the students. Students would be covered under school board insurance and the home requires a 2-step TB test and vulnerable sectors police check prior to beginning a placement.

Chapter 4

4 Physical Activity Recommendations

Two examples of physical activity options the home could include and/or expand, using the school partnerships, are a walking club and a gardening club. Both options fit well with the WHO requirements for physical activity for older adults outlined earlier (World Health Organization, 2010). The heterogenous population at this retirement home requires that activities offer accommodations for all functional abilities. These two options offer simple modifications to meet the abilities of all ages, and could be maintained all year long. To demonstrate the process the home could follow to match their available assets with program requirements, each program will be broken down based on the leadership, resourcing, and intelligence requirements for the programs.

4.1 Walking Club

Walking has proven to be an effective method to maintain physical health and high overall quality of life for older adults (Nelson et al., 2007). The program could be run by family members and students so that there is one aide to every one or two residents. Specifically, the university and college students could play a critical role in assisting any frail residents, while high school students could help by pushing wheel chairs. The students and family members should be trained by the Lifestyle Program Manager and/or GM before initiating the activity. Safety training would be very important for this activity as the residents may be away from the home and staff. Use of simple tests such as 'the talking test' could be used to ensure residents are not over exerting themselves (Centers for Disease Control and Prevention, 2015). The students and family members would need to be able to recognize health distress signs and have a phone available to call for the appropriate help. Other required training would be at the discretion of the home. The walking group could be run all year, with varying locations depending on conditions, using the home's bus for transportation. The mall could be used during the winter months while the summer, spring and fall offer more options such as the downtown, local walking trails, and the waterfront. Ideal locations would have ample seating available and level, smooth surfaces to walk on to accommodate residents of all abilities.

The major requirements for a walking club would include: a location/place to walk (safe for walkers), program leaders (enough to provide assistance for safety purposes), transportation (i.e. in winter months), and cells phones or other means to make contact in the case of an emergency. When considering the assets previously outlined in the asset maps, the following could be used to facilitate this activity:

Table 5: *Walking Club Activity Required Assets*

	Leadership	Resourcing	Intelligence
Internal	Lifestyle Program Manager, residents, and/or family	Lifestyle Program Manager could use knowledge and skills as a certified recreation	Lifestyle Program Manager to aide in organizing the walk

	members could recruit participants, plan and lead walks, and provide support/ safety on walks	therapist to properly assess, plan, and deliver the activity; paths around the home; bus for transportation; staff and/or family cell phones for emergencies	and supervising students; residents with experience walking the paths could inform the route and how far is reasonable
External	All students could recruit participants, plan and lead walks, and provide support/ safety on walks	Paths around the city; the mall; student cell phones for emergencies; in-kind hours from students to run the activity; college students could assist the Lifestyle Program Manager in assessing, planning, and delivering activity (using Recreation Therapy knowledge and skills)	Will depend on the students and their experience

The assets included in the table are not exhaustive, but provide a general idea of what would be required to implement such a program. The staff and residents at the home, and students completing placements/co-ops at the home would bring various experiences, knowledge, and skills that are not yet known in full but could contribute to the home's goals. This fact emphasizes the importance of the cyclic process and the regular updating of asset maps.

4.2 Gardening Club

Gardening is included in WHO's list of acceptable physical activities for older adults (World Health Organization, 2010) and has also been shown to help re-create a sense of home in later life, such as after moving into a retirement home (Bhatti, 2006). Furthermore, plants and gardening have been shown to have effects on stress

reduction, increased physical strength and flexibility, decreased pain, and improvements in overall quality of life (Dijkstra, Pieterse, & Pruyn, 2008; Wang & Macmillan, 2013). Students would need to be trained by the Lifestyle Program Manager on safety; other required training would be at the discretion of the home. Information and assistance on plant care could be provided by residents who have experience gardening and/or by students. This would largely be a spring/summer/fall program but residents could also bring small plants indoors to maintain for the winter months (and all year). Any high school co-op students with an interest in carpentry or construction could be tasked with building seated/standing garden boxes, either at their school or under the supervision of the home's Maintenance Manager.

The major asset requirements for a gardening club would include: gardens, both raised and on the ground, planters that could be brought indoors in winter months, plants and/or seeds, watering can and/or hose, shovels, dirt, and experienced program leaders. When considering the asset maps previously outlined in the results, the following could be used to facilitate this activity:

Table 6: ***Gardening Club Activity Required Assets***

	Leadership	Resourcing	Intelligence
Internal	Lifestyle Program Manager, residents, and/or family members could recruit participants, and plan and lead the program	Lifestyle Program Manager knowledge and skills as a certified recreation therapist could properly assess, plan, and deliver the activity; watering can/hose, shovels; dirt; plants/seeds; resident knowledge of proper plant/crop care	Lifestyle Program Manager to aide in organizing and supervising students; residents and/or staff with experience gardening or growing crops could aide in the process
External	All students could recruit participants, plan and lead walks,	College students could use their knowledge and skill in Recreation Therapy to assist	Will depend on the students and their experience

	and provide support/safety	the Lifestyle Program Manager in facilitating the activity; in-kind hours from students to run the activity; possibly in-kind resources from school to facilitate building boxes and/or caring for plants	

The assets included in the table are not exhaustive, but provide a general idea of what would be required to implement such a program. The staff and residents at the home, and students completing placements/co-ops at the home will bring various experiences, knowledge, and skills that are not yet known in full but could contribute to the homes goals. Additionally, with a program such as this, it is important to note the assumption of in-kind contributions from schools, for example, resources to help build garden boxes. An alternative option would be some additional costs that the home would need to account for.

Chapter 5

5 Discussion

The goal of this project was to provide a retirement home with recommendations and a quality improvement process to improve the choices of physical activities provided for residents. To do so, a CCB approach was chosen for its benefits to residents' physical, social, and psychological health as well as the economical benefits of partnering with previously established community resources. Baillie et al.'s (2008) framework was followed as it was unique in that it provided a conceptually based framework on how to build capacity as opposed to the many experientially or logically based guides commonly found in the literature (Verity, 2007). The three key elements to CCB outlined by Baillie et al. (2008) (leadership, resourcing, and intelligence) provided a foundation on which to build capacity within the home. It also informed the 'how-to' by offering

further detail when identifying assets in the community. By recognizing influential leadership, enabling resources, and intelligence in the form of experience, a more purposeful process emerged. The asset mapping steps described by Beaulieu (2002) and Kretzmann and McKnight (1993) are meant to be continuously repeated and updated. When amalgamated with Baillie et al.'s (2008) key CCB elements and mutually beneficial partnership development, an updated process for building community capacity emerged. The circular nature of the process is significant as the community, circumstances, and populations will inevitably change and thus the assets available will change as well. This amalgamated methodology that was used was different from other approaches found in the literature because it added Baillie's building blocks to provide more purpose to the asset mapping methodology that was used.

One unique aspect of this process was that for a partnership to be deemed feasible, it also had to be mutually beneficial. It was this stipulation that supported the formation of partnerships with multiple educational institutions. The student involvement at the retirement home would not only add valuable knowledge and skill, but also the benefit of having 'extra hands' available (in-kind resources) to lead activities on days when the Lifestyle Program Manager could not. Before letting the students lead activities though, it would be important to ensure proper training and knowledge translation to guarantee successful implementation of these physical activities. A train-the-trainer model which uses one 'expert' to train and over-see the training of others, who then apply their training and knowledge elsewhere (Suhrheinrich, 2011), would be an effective method to achieve this. Train-the-trainer has been described as both sustainable and cost efficient, as the programs regularly rely on existing resources within the organizing establishment, and can be maintained within the community by those who are trained (Orfaly et al., 2005; Suhrheinrich, 2011). This fits well with the budget constraints of the home and the CCB approach used as it encourages collaboration and learning from other leaders/experts in the community. Sustainability can also be further enhanced by the Lifestyle Program Manager training residents to implement and lead activities, using their wealth of experience and practical wisdom. This will have effects on improving resident quality of life through community engagement and continuing education (Boulton-Lewis, 2010; Cannuscio et al., 2003). Although, an important stipulation on the

use of this approach is the requirement of the Lifestyle Program Manager to alter their responsibilities slightly. This requirement and challenge was also reported in the research by Kaplan et al. (2006) where staff took on additional tasks with no reprieve from existing work in order to implement their intergenerational CCB project. For the current project, it would require taking on more of a management/training position rather than leading activities, which the students will be trained to do, an idea, which importantly, was not dismissed when proposed to the Lifestyle Program Manager.

An additional benefit of partnering with local schools is the introduction of intergenerational contact and collaboration between students and residents. Intergenerational programs have proven to have health and social benefits for both seniors and youth. The research has shown that social skills, aging awareness, and school attendance have all shown to increase for youth; while older adults have experienced increased memory, enhanced physical mobility, and improved sense of social connection (Kaplan et al., 2006). On one side of the partnership, the program coordinators and students together can provide leadership that can influence school administrators, other students, and residents. While on the other side of the partnership, residents and retirement home staff can provide leadership, influencing students and other residents. There is also the opportunity for knowledge and skills to be passed from instructors to students to residents, as well as from residents and staff to students. The experience of program coordinators is what would allow the partnership to run smoothly, but it is the experiences and practical wisdom of the residents that would be invaluable to informing and developing new physical activities. Furthermore, the opportunity for seniors to act as mentors and leaders to students would give residents a new sense of purpose and empowerment, and from this, the capacity of the home can grow.

By offering opportunities to residents to act as mentors, lead programs, and develop activities, the home would be enhancing the possibilities for residents to take control of their own lives and thus instilling a sense of ownership and empowerment (Rappaport, 1981). Hence, by focusing on physical activities specifically, the home would be empowering residents to take control of factors effecting their health, promoting a culture of ‘helping ourselves and engaging others’. Engaging and participating with the

community within the home and the city would empower and increase the capacity of residents. These outcomes would have residual effects that would be seen in the overall health of residents and their quality of life (Jackson et al., 1994; Winstead et al., 2014), which adheres to the mission and values of the retirement home.

Presented below is an adapted model that could provide the home with a process to follow in the future, allowing the home to explore new partnerships in the community and to continue building capacity. The variability found among CCB projects is likely a result of no set methodology existing in the literature. Often missing are important details on the implementation and evaluation of programs and activities. A focus on how to implement a new program is equally as important as the program itself, while evaluation of the program is essential to improvement of existing activities and informing the development of new ones (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). As a result, this model was adapted from Baillie et al.'s (2008) (needs-based) intervention management cycle. The asset-based partnership methodology presented for this project was added to the cycle. Additionally, the implementation and evaluation steps are expanded from Baillie to include parallel outcome measures for both CCB and the specific physical activities that are being implemented (Labonte et al., 2002).

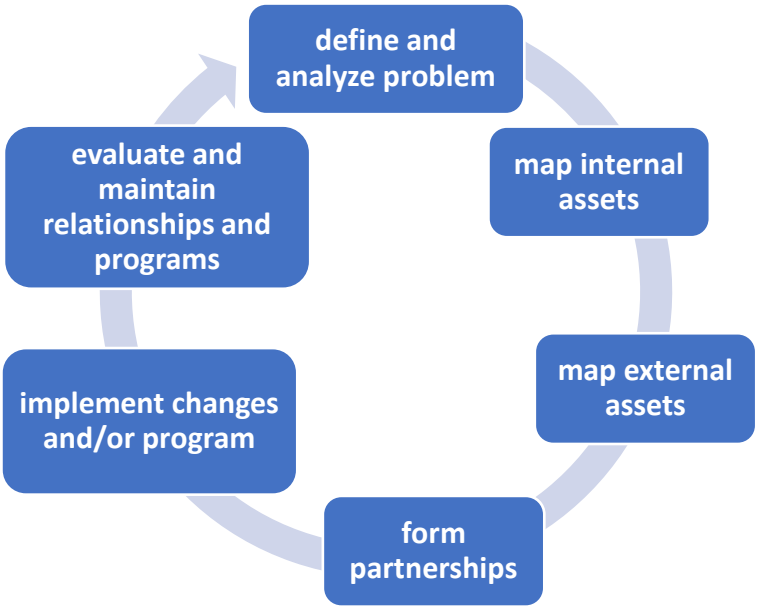

Figure 2. **This adapted model illustrates the cyclic process of the CCB, asset-based, partnership methodology.**

As illustrated above, the process begins once a problem is introduced and clearly defined, broken down, and analyzed, to gain a complete understanding of the context and situation using any informational resources available. A map of internal assets should be collected first as they are more easily accessed and could have a more direct impact on capacity building. External assets should then be mapped knowing what internal assets are available. Partnership formation should begin based on identified internal and external assets. The next steps of implementation and evaluation are very important to the success of any proposed changes. A focus on how to implement a program/change will be imperative as often times these details are ignored and implemented programs fail (Baillie et al., 2008; Labonte et al., 2002). Likewise, evaluation of the implemented programs/changes will be just as important, as increasing program options, since using a CCB process does not guarantee that the programs will be successful or achieve desired goals (Baillie et al., 2008; Myers, 1999). It is in this way that Labonte et al. (2002) parallel outcome measures should be used, evaluating both CCB and program specific outcomes. For example, in the walking club described above, process evaluations should be completed using attendance and drop out records, and by keeping a record of any issues, complaints, and/or suggestions presented throughout. As well, outcome evaluations should be carried out using pre- and post-program focus groups and program specific outcome measures (e.g., in the walking club, distance walked would be an effective outcome measure). The original problem should also be revisited to ensure that the implemented changes did in-fact have an impact (i.e., there are more activity option and better attendance). To evaluate the CCB process, partnerships should be evaluated through the formation of a partnership advisory committee which would meet regularly to ensure the mutual benefit and intended outcomes have occurred, as was done in Kaplan's (2002) CCB project. Using the walking and gardening club examples above, the advisory committee could include the GM, the Lifestyle Program Manager, one or two residents, and a representative from each school. The advisory committee and evaluation of the partnerships would be critical to sustainability and to continue capacity building efforts.

It is also noteworthy that while educational institutions were the only partnerships used in the present study for the recommended physical activities, the retirement home could

continue to seek out and form other mutually beneficial partnerships in the future. Furthermore, the partnerships need not only address improvements in physical activity options, but could include other activities important to the home and its residents. For example, the Age Friendly movement in the city provides an excellent opportunity to collaborate with the city as they introduce changes to meet WHO standards. The city could use the residents to pilot or test programs/changes being proposed, with the city benefiting from their feedback; and the residents benefitting from the change and involvement with the community. As well, the 50+ Activity Centre expressed explicit interest in future partnerships with the home even though they did not wish to pursue a partnership at the time of this project.

5.1 Limitations

Some limitations of this project include the period of time (2 weeks) spent at the home. This may have affected the ability to fully discover the capacity (leadership, knowledge and skills, and intelligence) of all residents and external assets in the city. As well, the brief time frame did not allow for a thorough evaluation of the effectiveness of the proposed model. However, introduction of the project was well received by all stakeholders, who were enthusiastic about the potential of the project and their involvement. Evaluation of the proposed model would be a beneficial option for future research which could be done by completing the cycle, and collecting process and outcome evaluation information to validate the utility of the model. Another consideration was that there was no guarantee that the residents interviewed were representative of all residents at the home. More complete sampling of resident experiences would have provided a more complete picture. To prevent this in the future, it would be beneficial to collect this information upon a resident's initial move into the home as part of the intake process.

5.2 Conclusion

The recommendations and model proposed will give the home a place to start, picking up where this project left off and continuing to build capacity and maintain relationships. A focus on physical activity being socially engaging and fun will be helpful with older

adults in a retirement home setting to support the uptake and sustainability of physical activities. As well, it would be important to provide choices to the residents, and to empower them by including them in the planning implementation process.

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Appendices

Appendix A: Field Notes

Trip #1 field notes:

Tuesday, February 23, 2016 (Day 1)

- General manager (GM) told me there are 64 residents total, some dementia patients
- spoke with Lifestyle program manager's (LPM) placement student (PS) who says some residents think the atmosphere (in the home) has decline over the years →PS is in occupational therapy assistant program at local college and is completing required placement rotation in senior living
- Was given a list of residents by nurse with some highlighted as "no talk" people for various reasons including dementia, grumpy, anti-social → had good intentions I think but seemed to have negative views of residents that made me feel slightly uncomfortable
- observed morning exercise class → instructor was very boring and dry
- PS says LPM only at home 2-3days per week; also, provided me with lifestyle questionnaires she was working on with residents – they were incomplete
- **get all management job descriptions
- 10:30am staff meeting every day in GM's office
- PS says the same people come out to activities, groups may change sometimes depending on activity but typically always the same people
- Spoke casually with residents about how they like living at the home
- Spoke with resident 1, very friendly and chatty
    - Says no activities planned
    - Would enjoy music if it was not too loud
    - Only really likes to do things with family (her sister also lived at this home)
    - Does not see doctors as they are responsible for their own and she does not have one

- **what is standard in other homes? Will need to compare
- Spoke with resident 2, a wheel chair bound stroke survivor
    - Thinks staff are great people but that they put on an act to make it seem like a good establishment, thought it was very much run as a business → seemed to have a negative view that he just accepted as 'business'
    - Enjoys socializing and people; kept saying he still "has his mind"
- Spoke with resident 3, a dementia patient
    - Likes living at the home says, "they've very good here and give you choice"
    - Enjoys singing and the bean bag game
    - Seemed to be in a good mood and very friendly despite being on the 'no talk' list
    - Kept telling me she's still learning at her age and how she is as stubborn as a mule
- Shadowed PS for most of the day and observed a 'regular day'

Wednesday, February 24, 2016 (Day 2)

Thoughts

- In home "general store" run by residents → are there restrictions on what residents can bring to their room?
- Is there some kind of home council group? could help to plan monthly activities and make changes around home
- Companion program? (i.e. reading buddy with elementary students)
- Brochures for family members??
- In-home/room exercise kits
- Dance classes – seated or standing
- could use hand rails around home to show exercises residents can do on their own
- Nordic walking sticks

- met with GM quickly before she had another meeting, had list of questions based on what was heard the day before
    - how long has the current LPM been working here? How long have you been here? → LPM – one year, GM – 6 years
    - who sets activity program each month? → LPM
    - what limitations are there when this is being set? →budget, facilities, transportations (although mentioned getting a bus for the residence next month)
    - are residents responsible for their own check-ups and doctor visits? → Yes, responsible for own doctors but have nurse (RPN) present and regular 'Blood pressure & weight loss Clinics' so residents can self-manage
    - have you noticed changes in atmosphere and activity levels over the years that you have been here? → believes that has been improvements and an increase in activity since she started and says she takes the opportunity very seriously and wants to see change
    - Is physiotherapy offered at the home? → Yes, depending on doctor's orders
- Spoke with resident 4, been living at home for 2 years, fairly active and involved
    - Her kids moved her in after she hurt her back while gardening and got sick; was living alone
    - Has grown to like it here, was miserable when first moved in though
    - Has tried all the activities but hurt leg in exercise class once so no longer participated in that
    - Enjoys walking outside in summer and around the halls in other months but gets out more in summer
    - Use to enjoy watching hockey
    - Says she needs a new hip and new knees

Thursday, February 25, 2016 (Day 3)

- Long trip to home due to bad weather – missed morning exercise class →PS said 9 people attended

- Had weight & BP clinic, residents were lined up out the door to have their blood pressure and weight taken
- Sometimes after measurements are given, the wellness manager (WM) or nurse will give residents recommendations
- Noticed signs all around home recommending ½ hour of exercise each day to remain independent and that 3x per week is not enough
- GM says any time there is a talk or session or clinic on health, like blood pressure or diabetes, residents will line up for it but when it comes to actually making the changes they don't think they need to
    - Says her home won best home in Canada in 2015 for resident satisfaction
    - Also thinks mental health is another big issue as many residents don't want to accept that socializing and getting out of their rooms is good for them so they stay isolated and become depressed
    - Gave example of resident 4 (who told me she hurt her back and had to move in) – children found her overdosed in her home; she had apparently deteriorated over previous 9 months after husband died and was very dependent on her children
    - When asked about required training (i.e. anti-ageism) for staff GM mentioned that she thinks all current training programs just reinforce coddling and patronizing attitudes
    - Feels that patronizing attitude many people use when dealing with seniors is a major issue and that in trying to avoid elder abuse, people go too far and treat them like children causing many seniors to shut down and become dependent and can lead to depression and deteriorating health

Thoughts

- Seems to be many discrepancies between resident's beliefs and feelings and staffs on many topics (ex. How home is run, physical activity, engagement, etc.), GM has some very strong views
- Should ask about "typical resident" and special groups
- Walker/wheel chair, assistive device use
- Cost and requirements to live at home

- Had lunch with GM and the regional coordinator of the Stay on Your Feet Falls Prevention Program (SYFFPP)from North East LHIN
    - SYFFPP supposed to be introduced at home, has not yet begun do due set backs → Concerned about program funding running out and program ending
    - Discussed an 'at home exercise kit' feasibility and usefulness and maintaining independence and adaptability through constant change
- Attended a monthly birthday party for all February birthdays
    - Usually have a live band – cancelled due to weather
    - Played music from computer instead – residents enjoyed the option to choose the songs
    - Largest event attended since arriving (also noted by PS that this is always the most popular activity) – 25 – 30 residents attended
    - Many sang along or danced in their chairs; a few got up to dance on multiple occasions
    - PS informed me that one resident that was dancing was a trained ballroom dancer
    - Noticed a couple plugging ears if music was too loud
    - Some residents chatted and danced with visiting family
    - Had cake, 50/50 draw and sang happy birthday
    - Afterward, most went back to their rooms but one man played the piano for a group of ladies before leaving
    - Many smiles – good to see such high attendance
- GM mentioned introducing a resident wall with 1 – 2 page blurb on each resident as a way to get residents to know each other
- Observations around home
    - Sign in book in front entrance
    - Newspapers in front foyer seating are

    - Radio's on in common areas (i.e. activity room and front foyer)
    - Electronic photo album in front foyer
    - Hand rails in hall ways
    - Walkers parked outside dining room at meal times
- To ask LPM
    - About all activities offered
    - Turn outs (especially to requested activities)
    - Monthly meetings with residents
    - Most popular events
    - Changes observed since she started
    - About Rec therapy program she completed and other certifications she may have
    - What she does about/for residents who don't come out
    - Any one-on-one work done?
    - Opinion on what residents do, what they enjoy, their barriers and motivators, etc.
- Conversation with GM
    - Once in a while will have happy hour, paid for by home, and can have alcohol in their rooms – too expensive to hold regularly
    - 2795$/month is base fee, including food and social opportunities – extra for medication assistance and escorts
    - Must provide their own furniture
    - Can make a resident leave if unable to provide proper care or under landlord act
    - "typical resident"
        - 'the Ruth' (**not a real name)

- Some needy and anxious, sometimes fades when encouraged
- Easily frustrated →thinks due to transition and change as often residents are 'sent' to live here. Often know that it is what they need but are resistant – does fade with time
- Few residents with Alzheimer's and dementia
- Offer temporary guest stays to see if there is a good fit and if the home is able to provide adequate care
- Many stroke survivors
- ~15 with diabetes
- A hand full with COPD
- Almost all with arthritis – most common complaint and excuse
- Believes 9/10 have already given up
- Believes residents often have intention of changing but don't have the will power to maintain the change

Thoughts

- Could try classes targeting specific health conditions to try to increase attendance → a mix of information and activity
- Classes run by students to keep costs low?

Friday, February 26, 2016 (Day 4)

- Arrived in time for exercise class today
  - Different instructor today
  - 5 people, a couple women I have not seen at other activities – 2 people showed up late (total 7 in class)
  - Residents commented that 9am start is too soon after breakfast and asked for 9:15am
  - One man tapped his foot along to the music → although music sometimes seemed not age appropriate
  - Began with easy stretched then moved to larger muscle, more challenging exercises (ex. Sit-to-stand, leg extensions, etc.)

    - Was a wide variety of abilities in class – for some it seems too easy for others too difficult →would be good to have options to modify difficulty (i.e. with resistance bands or weights)
    - Class was 50min
    - No resistance work was done
    - Class run by a physio assistant – for individual work, physiotherapist does all initial assessments (booked through CCAC) and gives charts with details to assistant to perform with individual

- 10:00am pet visit with eddy the Pug and woman from St. John ambulance dog therapy program (although visit was scheduled for 10:30am)
    - Been coming since Christmas
    - 9 people came to see the dog; 4 stuck around entire time
    - Woman who is usually very quiet really opened up and another woman said that it made her day
    - Also, did a couple of individual room visits
- Spoke with resident 5, newest resident
    - Moved in 4 days ago
    - Very happy so far, everyone has been very friendly
    - Came to exercise class and plans to continue to help with stiffness
    - Have seen her out and about regularly
- Spoke with resident 6
    - Been living at home for a few months
    - Is happy here but does not like to leave her room, prefers to sit and read
    - Says that she has never exercised or played so why would she start now
    - I noticed she did attend the blood pressure and weight loss clinic → could use this to entice her to start/try some kind a physical activity, even if it is in her room

    - When asked about doing exercises in her room she said she might try it, as long as its in her room, but has no interest in joining or participating in anything else
    - Said she was recently diagnosed with diabetes but was never told to or prescribed any kind of activity to help manage it

- 2:00pm bingo for 1 hour
    - Quite popular, 16 residents + 2 visitors
    - Many of the regulars plus a few unfamiliar faces
    - Very sedentary activity and not very engaging aside from a bit of conversation
    - A couple residents sat alone
    - Winners receive either 0.75$ or 0.50$ and two treats (chocolate or candy)
    - Might be nice to liven it up some how
- Spoke with residents 7 + 8 + their son and wife
    - They have been here for one year
    - French Canadians – she was energetic, happy and very talkative – laughing and smiling the entire time – he was rather quiet (French is his first language) but did speak a little
    - She says she would like to go out and do things (loves to socialize) but she is too afraid to leave him because of his health (he has fallen out of bed and is not supposed to lay down after meals due to heart attack risk)
    - When asked what they used to enjoy doing she went on about singing and piano as she used to be a piano teach, as well as socializing with people – says she goes for walks in the halls or sometimes sits in the door way to chat with people as they pass so she does not have to leave her husband
    - He likes hockey and use to be a welder but has no interest at all in getting up or leaving his room for anything – says that he walks when the weather is nice in the summer time but doesn't like winter and that he is just too old for activity

- Both say they know about the importance of activity but he says he still won't do it and she won't because she won't leave him
- Son + wife showed up then and agreed to tell me about their thoughts on the home – very negative at first, referring to the GM as 'fee for that' and had very negative things to say about cost and all the hidden fees they do not tell you about before moving in → when I suggested that it is not the GM who sets the fees he continued expressing negative views on the entire world in general, even laughing at me for attempting to change seniors habits in any way
- By the end of the conversation the son's perspective was maybe slightly more positive but his parents were clearly bothered by his somewhat harsh views and agreed to go for a walk with me later that day for the next.

Saturday, February 27, 2016 (Day 5)

- Arrived 8:45am; was very quiet, even less people out at breakfast
- Spoke with resident 9
  - 5th year at the home and likes it very much
  - Came on her own – was living with her family but decided it was time to leave and no longer burden them
  - Very active and knows the importance but does admit that she has days where moving from one chair to another is a struggle and her body just does not want to move
  - Says there are other residents who never leave their rooms and in her 5 years at the home there are people who she has never seen out except for at meal times
  - Admits that she gets out more during the summer time, walking and use to garden (but is too hard to bend over now) – says that it is always the same people that get out more in the summer, they are the same ones who are always at activities and she does not believe that people will do anything they don't want to and more don't think they need to do physical activity
- 10:30am a volunteer came in to give manicures
  - ~5 ladies came to get their nails done, a few more walked by to check it out but did not participate

    - Volunteer said usually more people show up
    - Volunteer also helps with bean bag game and says it is the most popular and normally has a large turn out

- Left for lunch with SYFFPP coordinator from the north east LHIN and her daughter who is looking to potentially get involved with this project
    - Discussed how she could potentially help out as well as individualizing activities for specific target populations
- 2:00pm return and home was quiet except for a group of 4 (3 residents, 1 family member), playing cards in the activity room
- 2:30pm I recruited a group of residents to play cards – got about 6 people out of their rooms to participate → all seemed to appreciate the invite and something to do
- Before leaving the husband and wife asked if we could all go for a walk tomorrow → maybe I had an impact yesterday?

Sunday, February 28th, 2016 (Day 6)

- Arrived 8:30am – took a cab due to extremely snowy conditions
- One woman was sitting in foyer waiting to go to church, one man was up walking the halls and another man was bundled up and walking outside back and forth on the sidewalk (this man gets out to walk every day, no matter the weather, but is rarely seen otherwise)
- Breakfast was fairly empty again, was mentioned that many residents will opt to eat in their rooms
- One resident asked me immediately if we could play cards again today and another man asked me to visit him later on → it seems as though residents are starting to get use to my presence
- One woman who played cards yesterday told me that one of the men who played told her how much fun he had playing cards with us yesterday
- 3 separate residents have told me how they wish they could go out and shovel or just be out in the snow, another woman described how she use to skate, toboggan, and snow shoe all the time → I think this speaks to the different life of rural living and how we must target activities to resident interests – we cannot use cookie cutter programing when the recipients vary so much

- Some with the RPN (an older woman) who has been working at this home for 3 years
    - When asked what she things the largest barriers are for the residents participating in activities she replied with:
        - Some seem childish (ex. Adult colouring → residents don't know or care that it's the newest fad)
        - Activities are not always age appropriate
        - Residents hurt and/or have no ambition
        - Not enough people go and seems trivial
    - She said she would not call this a regular or typical retirement home due to the amount of care many of the resident need
    - Thinks a major issue is not having a full time LPM due to budget constraints
        - Also thinks the residents often don't relate with the LPM as they are normally younger and are not around as often
    - A common complaint heard by the nurses is that they have nothing to do
    - Thinks a good place to start might be having someone go to the resident's room and bring activities too them
        - Gave example of one resident who can hardly walk and said why would they want to cause themselves extra pain to leave their room and do a childish activity that not many people go to and they probably don't know anyway
    - Also thinks that the weekend activities are cop-outs, giving the examples of "read the paper, go for a walk", thinks it just seems like they are trying to make the calendar look full
- Met with resident 2 who asked to speak with me in the morning
    - Moved in Nov. 4th, 2015 – was on his own before that
    - Use to take care of his wife (has Alzheimer's and osteoporosis) until 08/09 when she was moved into a home
    - Had a stroke in 2012, wheel chair bound now and can't do much activity

    - Thinks this home is a good place for retirement but also noted that there is good and bad with everything
        - He feels that the management treat himself and other residents like 3 year old's, he thinks everything they do is for show, that they have no people skills, and all they care about is running their business
    - when he was younger, he and his wife loved to travel, often by car, and did a lot of camping with his three children
    - he used to golf and fish when he could find the time
    - thinks that a computer room would be a great addition to the home and really enjoys the hymn sing which he attends weekly

- when to visit the couple who wanted to go for a walk – surprisingly the husband was all for it and the wife was trying to get out of it. We agreed to go after lunch
- spoke with residents 10 + 11
    - both really enjoy music and dancing as well as playing cards (which they asked to play later)
    - 11 relies on 10 for a lot of little things and jokingly refers to her as his nurse
- Walked up and down halls with couple after lunch, wife was fairly stable and quick and tried to read all of the names as we passed rooms, husband was slower but kept up fairly well (said he use to do that walk all the time)

Thoughts

- Look up activities/games included in the seniors Olympics in London
- Could not contact city hall – must visit on next trip

- Spoke with another woman who says that the activities are not what they use to be and also that she can no longer so some the things she use to enjoy, like puzzles

Trip #2 field notes:

Meeting @ College with Program Coordinator, Tuesday June 7, 2016 – 9:00am

- Rec therapy students have done many placements at other retirement and long term care homes in the city but have worked very little with Home
- Asked about activity pro documentation program used by Recreation therapists
- First semester, from September – December → assessment course (~30-40 students in class, 2nd year Rec therapy students) Introductory course (~50-60 students in class, 1st year rec therapy + 2nd year recreation students)
- Asked if home used the RAI – Resident Assessment Tool, is commonly used in LTC
- Second semester, from January – April → programming course (1st year Rec therapy students)
- Asked for Home requirements of students
- Practicum requires students to have a supervisor (at the home) and goals for their time at home
- Students can also individual goals set with the retirement home
- Option for students to around and do individual assessments with those residents who do not leave their rooms often
- Supervisor must submit a review of the student at the end of placement
- Students are covered under the colleges insurance
- Suggested that students provide some kind of educational presentation prior to implementing their program (all of which must be approved by the supervisor (LPM?)
- Overall, meeting went very well. Coordinator was enthusiastic and seemed to see great potential in this collaboration with home

Meeting @ High School with two Co-op Supervisors, Tuesday June 7, 2016 – 11:00am

- High school coop students have done work with home in the past although the Recreation program is fairly new so they have not had students placed there to work in that area
- One – on – one work with residents is an option (perhaps just a personal/social visit to keep residents engaged)

- Beneficial to have set schedules for students so they can be independent with some guidance
- Students would be present from Monday to Friday for full or half days → 110 credit hours required
- Preplacement requirements covered in class 2 weeks before beginning placement – includes health and safety, resumes, WHIMIS, etc.
- Students are in class and/or working on an assignment once each month
- Mentioned a wide range of interests in high school students so they could be spread out with their task (ie. computer interests could do work on excel)
- LPM/the supervisor must meet with the teachers, a very open and transparent relationship is excepted between the student, teacher and supervisor – will often have random check ins on site and this must be okay with the home
- Students complete journals once a month
- Mentioned ability to pick and choose their more motivated/interested students to be placed at home (as many as needed)
- Since LPM is only present 20hrs/week, students would need someone else supervise/report too
- Students are covered under the school board insurance

Thoughts

- Will need to consider home required training for students and timing of training as high school students and post-secondary students will have different semester lengths
    - Will they require the same training? Will this be too demanding/too much extra work for LPM? Will GM be okay with a slight shift in LPM role?
- Keep in mind that home is not required to use all students from all schools – they can decide based on their needs

Meeting @ University with Placement advisor, Wednesday June 8, 2016 – 10:30am (placement package in appendix)

- 3rd year students rank interests out of options provided and are placed somewhere, 4th year students get to choose their placement and have option of going outside those offered by the university

- Required 50hrs over the year
- Students must provide placement coordinator with proposed work schedule
- There are a few forms for the placement supervisors to sign and an evaluation to complete upon completion of the 50 hours
- 3rd years have an on-going online discussion and are required to submit a log book
- 4th year students have a reflection paper
- Students must sign an insurance release form
- 3rd year students can complete their placement in the fall/winter term but 4th year students have the option spring/summer option (although enrollment tends to be low)
- Host (i.e. retirement home) would need to sign off on hours for student
- Would need a clear description of duties a few months before placement to post online so that students can decide and sign up

Brain Storming group with residents, Wednesday, June 8th, 2016 – 2:00pm

- 8 residents participated in focus group, held in activity room
- Very relaxed setting, sitting in a circle
- Residents seemed to feed off each other, often agreeing with and adding onto each other's comments
- May have been beneficial to have a wider variety of residents present as most who attended were those who already participate regularly → tried to invite some who do not come as often but they either agreed and then did not come and declined outright
- Residents were asked:
    - Favorite activities/things to do (past and present)
        - Reading
        - Gardening
        - Baking/cooking
        - Scouting (once kids left)

  - knitting
  - Video games
  - Hymn sings
  - dancing
  - Music
  - Writing
  - Crafts + jewelry
  - Being physically active
  - Caring for their children
- Barriers/limitations to participating in these or other activities
  - Day-to-day health
  - Weather
  - ***soreness and pain (all agreed to this one)
  - No kitchen or ingredient access
  - Do not always have an interest in leaving their room
  - Sometimes willing to try something new, but bad experiences are a big turn off
  - Slow to get moving in the morning (i.e. can't always make it to morning exercise)
- Things you would like to do/see offered
  - Horse shoes
  - Outdoor activities
  - Gardening (raised boxes)
  - Resident cook book
  - Waterfront trips
  - YMCA memberships (i.e. to go swimming, or to see kids swimming)
  - Knitting groups
  - Sewing (i.e. could make quilts)

        - Indigenous singers + dancers
        - Monthly culture day
        - Trip to Laurier Woods
        - Reading buddies
        - Presentations
    - Time of day preferences
        - Morning – 1
        - Afternoon – 5
        - Does not matter – 2

- Spoke with LPM briefly before an activity
    - A bus for the home is in the works → maybe by the end of the month – LPM will be the driver
    - Home will require students to have vulnerable sectors police check and a 2 step TB test
    - Home has tried to work with YMCA before with past students – took some residents to swim – but was not a large turn out and risk of falls was very high (experienced a close call with one resident)

Thursday, June 9th, 2016

- Visited city hall (9:30am)
    - no one at front desk has ever heard of any age friendly plan or aging initiative and did not know who they could direct me to that would have more information on such a program
    - collected some fliers and pamphlets located in the front foyer on city activities – might be a good idea to bring some of these into the home or incorporate into GM's 'around the city' board idea
- Visited seniors club down town – no one available to speak at the time, told to call later on
- Called seniors club and transferred to one of the organizers about their services

    - 20$/year membership provides reduced costs at various events and activities throughout the year
    - Offered to anyone who wants to participate (do not have to be a member)
    - Club is open Monday – Friday and hosts dances every Saturday plus the occasional weekend event
    - Variety of activities offered, from exercise classes and line dancing to card making and shuffleboard
    - Said that this retirement home use to be very involved with the club but they experiences a falling out some years ago – relationship was never rebuilt since → (from speaking with this woman and with the homes GM it sounds like it was an issue/disagreement to do with money, donations and time that caused the relationship to fade)

- Email SYFFPP representative from LHIN about no information at city hall about age friendly initiative → email was forwarded to individual in charge of that program

Appendix B: Resident Demographics

Yrs at Home		Move in Date			Sex		Birthdate			Age	marital status		
		month	day	year	F	M	month	day	year				
2		10	6	14	x		4	7	1933	82	w		
2		10	10	14		x	12	1	1941	74	W		
3		7	30	13		x	8	25	1933	82	w		
4		3	20	12	x		9	6	1927	88	W		
0		2	16	16	x		10	18	1936	79	w		
3		3	21	13		x	2	24	1928	87	W		
3		10	7	13		x	12	30	1920	95	w		
2		6	23	14		x	3	17	1924	91	w		
3		1	21	13		x	5	30	1931	84	w		
1		11	6	15		x	11	4	1949	66			s
10		2	4	6	x		1	23	1922	93	w		
1		9	15	15	x		11	5	1929	86	w		
3		6	3	13	x		8	26	1921	94	W		
2		11	4	14		x	3	12	1931	84	w		
11		9	26	5		x	7	17	1944	71			s
1		5	21	15	x		10	18	1930	85	w		
1		5	30	15	x		2	19	1936	79	w		
5		2	7	11	x		10	21	1928	87	w		
4		12	18	12	x		7	13	1919	96			s
1		4	17	15	x		12	18	1926	89			
2		7	1	14	x		7	1	1928	87	w		
2		11	18	14	x		11	14	1935	80	w		
5		7	7	11	x		4	11	1938	77			s
3		4	24	13	x		1	22	1929	86	w		
2		5	7	14	x		2	10	1932	83	w		
3		10	15	13	x		9	17	1918	97	w		
2		8	20	14		x	4	14	1929	86	w		
4		1	3	12	x		4	14	1926	89	w		
1		9	7	15	x		4	5	1931	84	w		
3		1	9	13	x		8	22	1923	92	w		
6		12	16	10	x		11	11	1936	79	w		
3		1	22	13	x		7	11	1927	88	w		
2		11	3	14	x		2	24	1919	96	w		
2		5	8	14		x	7	13	1933	82	W		
1		4	15	15	x		9	17	1944	71	W		

3		7	15	13	x		1	19	1928	87	W		
1		1	29	15		x	8	25	1934	81		M	
1		1	29	15	x		4	30	1933	82		m	
2		6	21	14	x		3	23	1932	83			s
1		11	21	15		x	11	20	1922	93			
1		5	22	15	x		10	3	1945	70	W		
1		3	1	15	x		5	11	1930	85	w		
2		1	28	14	x		1	19	1932	83	w		
1		3	28	15	x		7	5	1929	86			s
1		3	28	15	x		7	12	1934	81			S
1		1	19	15	x		7	9	1924	91	W		
3		4	19	13	x		4	30	1926	89	w		
2		6	25	14	x		1	31	1919	96	W		
2		11	1	14	x		11	4	1934	81	W		
6		8	19	10	x		1	2	1921	94	W		
4		5	23	12		x	4	25	1925	90	W		
6		9	6	10	x		7	16	1932	83	W		
4		6	15	12	x		6	26	1942	73	W		
5		10	19	11	x		11	30	1925	90	W		
0		2	22	16	x		9	11	1936	79	w		
4		11	12	12	x		3	18	1947	68			S
1		12	5	15		x	10	25	1950	65			D
4		4	29	12	x		1	8	1930	85	W		
4		6	14	12	x		6	13	1922	93	W		
5		1	10	11	x		1	28	1926	89	W		
2		9	23	14	x		2	23	1930	85			s
4		1	25	12	x		1	1	1927	88	w		
3		10	1	13		x	11	14	1941	74			s
1		8	8	15	x		7	13	1931	84			
2		1	8	14		x	11	21	1917	98	w		
average of 3 years at home					48	17			average age 85				
				Number of residents		65							

Curriculum Vita

Name:	Charlotte W. Crombeen
Post-Secondary Education:	Simon Fraser University Burnaby, British Columbia, Canada 2010 – 2015, B. Sc. Kinesiology, Certificate in Health and Fitness
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